

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2009
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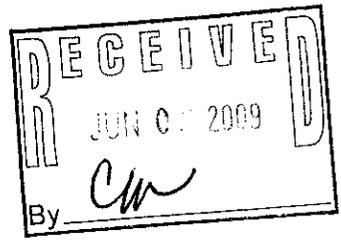
NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4012 LEE STREET, NE WASHINGTON, DC 20019
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W 000 INITIAL COMMENTS

A recertification survey was conducted from May 12, 2009, through May 13, 2009. The survey was initiated using the full survey process due to the facilities history of condition level deficiencies during the previous survey period. A random sample of two clients was selected from a client population of four males with various disabilities.

W 000



The findings of the survey were based on observations at the group home and two day programs, interviews with management and staff, and the review of habilitation and administrative records, including the facility's incident management system.

W 153 483.420(d)(2) STAFF TREATMENT OF CLIENTS

W 153

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.

W153

The injury to client #1's upper left eye was not of unknown origin it was based on a behavior episode where he hit himself. His injury was assessed by nursing, deemed very minor with minimal follow up treatment required. The slight bruise to the area resolved itself in a matter of days and client #1 exhibited to pain or discomfort during the healing period. The QMRP will retrain staff on appropriately completing incident reports and notifying the appropriate parties. The training will occur by...6-7-09.

This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the administrator and the Department of Health (DOH) as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) for one of the four clients residing in the facility. (Client #1)

The finding includes:
The review of the facility's unusual incident

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Bridget Clugston, Owner for Eulette Moore TITLE _____ (X6) DATE 6/2/09

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

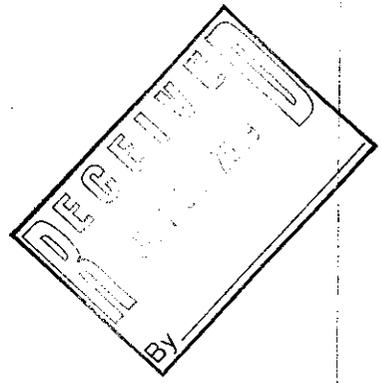
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W 000	<p>INITIAL COMMENTS</p> <p>A recertification survey was conducted from May 12, 2009, through May 13, 2009. The survey was initiated using the full survey process due to the facilities history of condition level deficiencies during the previous survey period. A random sample of two clients was selected from a client population of four males with various disabilities.</p> <p>The findings of the survey were based on observations at the group home and two day programs, interviews with management and staff, and the review of habilitation and administrative records, including the facility's incident management system.</p>	W 000		
W 153	<p>483.420(d)(2) STAFF TREATMENT OF CLIENTS</p> <p>The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all injuries of unknown origin and serious unusual incidents were reported immediately to the administrator and the Department of Health (DOH) as required by DC regulation (22 DCMR Chapter 35 Section 3519.10) for one of the four clients residing in the facility. (Client #1)</p> <p>The finding includes:</p> <p>The review of the facility's unusual incident</p>	W 153	<p>W153</p> <p>The injury to client #1's upper left eye was not of unknown origin it was based on a behavior episode where he hit himself. His injury was assessed by nursing, deemed very minor with minimal follow up treatment required. The slight bruise to the area resolved itself in a matter of days and client #1 exhibited to pain or discomfort during the healing period. The QMRP will retrain staff on appropriately completing incident reports and notifying the appropriate parties. The training will occur by...6-7-09.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bridget Clugston, RN, RCP for Eulette Moore</i>	TITLE	(X6) DATE <i>6/2/09</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 153 Continued From page 1 reports and interview with the Qualified Mental Retardation Professional (QMRP) on May 12, 2008 at 9:45 AM, revealed the facility failed to report the following injury:

On July 10, 2008, Client #1 was observed with an injury of unknown origin to his upper left eye. According to the report, Client #1 was evaluated and was treated for the injury. There was no evidence the facility reported the injuries of unknown origin immediately to the administrator and DOH.

W 154 483.420(d)(3) STAFF TREATMENT OF CLIENTS

The facility must have evidence that all alleged violations are thoroughly investigated.

This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that an injury of unknown origin was thoroughly investigated, for one of the two clients (Client #1) included in the sample.

The finding includes:

Cross Refer to W153. Interview with the Qualified Mental Retardation Professional (QMRP) and the review of the facility's Unusual Incident Report log book on 5/12/09 at approximately 9:56 AM, revealed that Client #1 had sustained an injury of unknown origin to his upper left eye, July 10, 2008. There was no documented evidence that this injury had been investigated.

W 159 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL

W 153

W 154

W154

See responses for W153 above.

W 159

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W 159 Continued From page 2

Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.

This STANDARD is not met as evidenced by: Based on observations, interviews with the Qualified Mental Retardation Professional (QMRP) and record review, the QMRP failed to ensure integration, coordination and monitoring of client's active treatment regimen for three of the four client in residing in the facility.

The findings include:

1. The facility's QMRP failed to ensure that day programs staff provided the appropriate eating utensil during meals.

On 5/12/09, client #2 was observed eating lunch at the day program at approximately 11:47 AM. He was observed to independently scoop his food with a plastic spoon and ate at a rapid pace. Later that same day at approximately 3:16 PM, he was observed eating a bowl of fruit with a regular teaspoon.

On 5/13/09 at approximately 2:45 PM, the QMRP was informed that on 5/12/09, client #2 was observed at the day program eating with a plastic spoon. The QMRP stated Client #2 was to eat with a regular metal teaspoon to assist with slowing his eating pace. Reportedly the smaller bowl of a teaspoon allowed for minimal amount of food to be scooped while the client was eating his meals. The QMRP assured this would be brought to the day programs attention.

2. The facility's QMRP failed to ensure that the

W 159

W159

1. The QMRP will meet with the day program personnel of client #2 to insure that he eats using the proper utensils and to insure that his eating pace is monitored. This meeting will occur by...6-10-09.

In addition, the QMRP will monitor lunch meals during her routine visits to the day program to insure ongoing compliance...6-30-09.

2. See responses for W189.
3. See responses for W210
7. See responses for W250
8. See responses for W252
9. See responses for W436.

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W 159 Continued From page 3
staff were trained effectively to complete their duties. [See W189]

3. The facility's QMRP failed to ensure that the Physical Therapist completed an reassessment on Client #2. [See W210]

7. The facility's QMRP failed ensure client's Individual Program Plan (IPP) objectives were incorporated into their individual activity schedules. [See W250]

8. The facility's QMRP failed implement an effective system of documenting a client's progress on his program objectives. [See W252]

9. The QMRP failed to ensure clients were taught to use and make informed choices about the use of their adaptive equipment. [See W436]

W 159

W189

See responses for W252.

W 189 483.430(e)(1) STAFF TRAINING PROGRAM

The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.

This STANDARD is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for one of the four clients residing in the facility. (Client #3)

The findings include:

The facility failed to ensure that direct care staff

W 189

W189

See responses for W252.

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W 189	Continued From page 4 documented program data according to the IPP objectives. [See W252]	W 189		
W 210	<p>483.440(c)(3) INDIVIDUAL PROGRAM PLAN</p> <p>Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the Physical Therapist reassessments for one of the two clients in the sample. (Client #2).</p> <p>The finding includes:</p> <p>Observation on 5/12/09 8:55 AM and on the same day at 6:45 PM respectively, revealed Client #2 was observed walking with a slightly unsteady gait and was wearing a gait belt around his waist.</p> <p>Interview with the Qualified Mental Retardation Professional (QMRP) on 5/13/09 at 1:00 PM, revealed that the client had a initial Physical Therapy (PT) assessment on 10/2/08, that recommended the use of a weighted vest during upper body exercise for a 3 month period. According to the QMRP, the client completed the three month therapy and was no longer using the weighted vest. Review of the program data reflected that Client #2 completed his participation in the therapy, January 2009.</p> <p>Review of the PT's monthly notes from October 2008 to current, failed to evidence that a</p>	W 210	<p>W210</p> <p>The Physical Therapist will review the status of the use of the weighted vest and develop a note that reflects his decision. The team will follow the mandates outlined...6-10-09.</p> <p>In the future, the QMRP will review the medical records monthly to insure that each discipline documents follow up and monitoring in the parameters outlined in their recommendations or in the ISP...6-30-09.</p>	

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W 210	Continued From page 5 re-assessment had been completed to evaluate if the use of the weight vest was effective and if the use of the vest should be continued or discontinued.	W 210		
W 250	<p>483.440(d)(2) PROGRAM IMPLEMENTATION</p> <p>The facility must develop an active treatment schedule that outlines the current active treatment program and that is readily available for review by relevant staff.</p> <p>This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that each client's Individual Program Plan (IPP) objectives were incorporated in their individual activity schedules for two of two clients in the sample. (Client's #1 and #2)</p> <p>The findings include:</p> <p>The facility failed to ensure that the activity schedules for Clients #1, and #2's were available and incorporated to include each client's current IPP objectives as evidenced below:</p> <p>On 5/13/09 at approximately 1:45 PM, interview with the Qualified Mental Retardation Professional (QMRP) and the review of the Individual Support Plans (ISPs) for Clients #1 and #2 respectively, revealed that the activity schedules were not current.</p> <p>Further interview with the QMRP revealed the activity schedule should have been revised after the client's ISP meetings. According to the QMRP, Client #1's ISP meeting occurred on 1/7/09 (four months prior) and Client #2 ISP</p>	W 250	<p>W250</p> <p>The QMRP revised the activity schedules of clients #1 and #2 to reflect their new ISP objectives and will insure in the future that the activity schedules are revised with in 3 days of the development of a new ISP...6-01-09.</p>	

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W 250	Continued From page 6 meeting occurred on 10/7/08 (seven months prior). At the time of the survey, there was no evidence that the each client's activity schedule had been updated to include their current IPP objectives and made available to the direct care staff working in the facility.	W 250		
W 252	<p>483.440(e)(1) PROGRAM DOCUMENTATION</p> <p>Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the implementation of an effective system of documenting a client's progress on his program objectives for one of the two client's in the sample. (Clients #3)</p> <p>The finding includes:</p> <p>The facility failed to ensure that direct care staff documented Client #1's maladaptive behavior of aggression in accordance with his Behavior Support Plan (BSP).</p> <p>On May 12, 2009 at approximately 6:07 PM, Client #3 was observed to hit a female staff person on the arm. At approximately 6:08 PM, Client #3 was observed to curse at the same female staff and hit her on the arm a second time. The one on one staff responded by asking the client to stop and redirected him to the dining room table to eat his ice cream cup from McDonald's. Through-out the time Client #3 was</p>	W 252	<p>W252</p> <p>The QMRP retrained staff on properly documenting the behavior episodes of client #3, focusing on both actual episodes of the behavior verses attempts to engage in the behavior...5-30-09.</p> <p>The licensed psychologist will conduct follow up training by...6-15-09.</p>	

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W 252	<p>Continued From page 7</p> <p>eating his ice cream he was mumbling to himself, looking at the same female staff. However, once Client #3 completed the ice cream he appeared to be calm.</p> <p>Interview with the staff on the same day at approximately 6:59 PM, revealed that Client #3 had a Behavior Support Plan (BSP) to address his maladaptive behaviors to include strategies to implement when an explosive outburst occurs. Review of the BSP on 4/12/09 at 1:30 PM, verified strategies to be implemented by the one to one staff, to include documentation instructions. According to the BSP, staff are to document every aggressive episode/incident on his BSP data sheet.</p> <p>Review of the BSP data sheet on May 13, 2009 at approximately 12:15 PM, did not evidence that the one on one staff accurately documented Client #3's aggressive outburst as observed. The data collection revealed that Client #3 attempted to hit the female staff. The data did not reflect that Client #3 actually hit the female staff person twice (2x) and cursed at her while he was in the dining room.</p> <p>According to the QMRP all staff have been recently trained on Client #3's BSP. Review of the in-service training log verified that staff were trained on Client #3's BSP 3/20/09 to include data collection requirements. At the time of the survey, there was no evidence that the Client #3's behavioral outburst was documented accurately in the program book.</p>	W 252		
W 331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs.</p>	W 331		

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W 331	Continued From page 8	W 331		
W 368	<p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility's nurse failed to ensure the coordination of health care services for one of two clients in the sample. (Client #2)</p> <p>The findings includes:</p> <p>The nursing staff failed to ensure that medications were administered in compliance with the physician's orders. [See W368]</p> <p>483.460(k)(1) DRUG ADMINISTRATION</p> <p>The system for drug administration must assure that all drugs are administered in compliance with the physician's orders.</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for one of the two clients included in the sample. (Client #2)</p> <p>The findings include:</p> <p>Observation of the medication pass on May 12, 2009 at approximately 7:13 PM, revealed that the medication nurse was unable to administer Client #2's PM dosage Mysoline 50 mg for his seizures because the medication was not available in the facility.</p> <p>Further interview revealed that the agency's nursing policy revealed that the LPN and the RN are to monitor the medication supply to ensure</p>	W 368	<p>W331</p> <p>See responses for W368</p> <p>W368</p> <p>MTS has established a nursing support office staffed with two support LPNs who are charged with ordering and tracking the delivery of required medications, among other tasks, using this office and other nursing supports in place, MTS will insure that all needed medications are obtained from pharmacy in a timely manner...6-1-09.</p> <p>It should be noted that client #2 missed one dose of the medication, the PCP was informed and there were no ill effects noted.</p>	

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W 368	<p>Continued From page 9 that each client's medications are available for administration.</p> <p>Review of the Medication Administration Records (MAR) revealed on the same day revealed that the nurse signed the back of the MAR that the medication was unavailable. According to the LPN she notified the RN who in turn contacted the pharmacy. The nurse confirmed that the medication would be delivered later in the evening and administered by the RN.</p> <p>On May 13, 2009 at approximately 10:15 AM follow up with the RN revealed that the pharmacy failed to deliver Client #2's medication the pervious evening. Review of the nurses note on the same day at 10:30 AM did not evidence that the RN contacted the physician to report the missed dosage of medication and did not evidence instructions for Client #2's missed dosage of medication.</p> <p>At the time of the survey, there was no evidence that Client #2 received his dosage of medication as prescribed for his seizures.</p>	W 368		
W 436	<p>483.470(g)(2) SPACE AND EQUIPMENT</p> <p>The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to teach clients to use and make informed choices about the use of their</p>	W 436	<p>W436</p> <p>The licensed psychologist will work with the QMRP to develop a tolerance program for client #3 to promote wearing the glasses...6-7-09. Staff will be trained on the protocol once developed...6-20-09.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 09G074	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2009
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NAME OF PROVIDER OR SUPPLIER MULTI-THERAPEUTIC SERVICES, INC	STREET ADDRESS, CITY, STATE, ZIP CODE 4012 LEE STREET, NE WASHINGTON, DC 20019
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W 436	<p>Continued From page 10</p> <p>adaptive equipment for one of four clients residing in the facility. (Client #3)</p> <p>The finding includes:</p> <p>The facility failed to ensure that the client #3 was taught to wear and maintain his eyeglasses.</p> <p>Review of Client #3's medical record revealed a Vision consult form dated 1/22/09, in which the client is to use his glasses. Observations through-out the survey on 5/12/09 and 5/13/09 failed to evidence that him wearing them.</p> <p>Interview with the direct care staff on the same day verified that Client #3 had the prescribed glasses, however refused to wear them. At 1:08 PM, on 5/13/09, interview with the Qualified Mental Retardation Professional (QMRP) verified that the client refuses to wear his glasses. According to the QMRP, the psychologist had not addressed and/or established to date, programmatic strategies to train the client on wearing his glasses and how to address his refusals. Review of the BSP, dated 3/20/09 did not evidence a target behavior for refusals.</p>	W 436		
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Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0232	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/13/2009
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1 000	<p>INITIAL COMMENTS</p> <p>A re-licensure survey was conducted from May 12, 2009, through May 13, 2009. A random sample of two residents was selected from a client population of four males with various disabilities.</p> <p>The findings of the survey were based on observations at the group home and two day programs, interviews with management and staff, and the review of habilitation and administrative records, including the facility's incident management system.</p>	1 000		
1 077	<p>3503.5 BEDROOMS AND BATHROOMS</p> <p>Each bedroom shall contain sufficient storage space for each resident ' s seasonal, personal clothing and personal effects.</p> <p>This Statute is not met as evidenced by: Based on observation and staff interview, the facility failed to provide individual closet space adequate for two of the four residents residing in the facility. (Resident #2 and #3).</p> <p>The finding includes:</p> <p>The facility failed to ensure that each resident was provided with appropriate and identifiable closet space for their personal clothing.</p> <p>Observation during an environmental walk-through on May 13, 2007 at 2:45 PM, revealed that a variety of clothing were commingled in the closet designated for Resident #2 and #3 use. Further observation revealed that the clothes hanging in the closet had no clear labeling system in order to determine which</p>	1 077	<p>3503.5</p> <p>The closet shared by residents #2 and #3 has been divided by a marker that identifies which side is for #2 and which side is for #3... 5-30-09. It should be noted that all clothing is marked in an inconspicuous place with the owner's initials.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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I 077	Continued From page 1 clothes belonged to whom.	I 077		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Internal 1. The light fixture leading to the basement was not working. External 1. The gutters surrounding the facility were cluttered with leaves and twigs. 2. The front and back lawn of the facility had not been cut.	I 090	3504.1 1. Light fixture repaired...5-30-09. 2. Gutters cleaned...5-30-09. 3. Lawn cut...5-30-09. The delay in cutting the lawns and cleaning the gutters was based on multiple, consecutive rain days. MTS will insure that environmental concerns are addressed in a timely manner via Facility Manager Audits weekly, reporting to the Program Assistant and planned follow up on the issues uncovered...6-1-09.	
I 161	3507.2 POLICIES AND PROCEDURES The manual shall be approved by the governing body of the GHMRP and shall be reviewed at least annually.	I 161	3507.2 The policy manual has been reviewed and updated for 2009 and the facility now has a copy of the updated manual...6-1-09.	

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I 161	<p>Continued From page 2</p> <p>This Statute is not met as evidenced by: Based on interview and record review, the GHMRP's governing body failed to review its policies and procedures annually.</p> <p>The finding includes:</p> <p>Review of the policy and procedure manual on May 13, 2009 at 2:50 PM, failed to provide evidence that the agency's policy manual had not been reviewed and approved annually by the governing body as required. The last noted date for review was in 1/30/08.</p>	I 161		
I 203	<p>3509.3 PERSONNEL POLICIES</p> <p>Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter.</p> <p>This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually.</p> <p>The finding includes:</p> <p>Review of the personnel files conducted on 5/13/09 revealed that GHMRP failed to provide evidence of a current signed job descriptions for the Qualified Mental Retardation Professional.</p>	I 203	<p>3509.3</p> <p>The QMRP had a current, signed job description (see: attached copy)...5-30-09.</p> <p>3509.6</p> <p>Updated health certificates have been requested for all of the staff/consultants mentioned and will be obtained by...6-15-09.</p> <p>MTS audits the personnel records quarterly and proactively to notify staff of upcoming issues. This process will continue and follow up will be tracked to resolution by MTS HR...6-30-09.</p>	
I 206	<p>3509.6 PERSONNEL POLICIES</p> <p>Each employee, prior to employment and annually thereafter, shall provide a physician's certification that a health inventory has been</p>	I 206		

Health Regulation Administration

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I 206 Continued From page 3

performed and that the employee ' s health status would allow him or her to perform the required duties.

This Statute is not met as evidenced by:
Based on staff interview and record review, the GHMRP failed to ensure its staff received annual health screenings in the form and manner as required by this section.

The findings include:

Interview and review of the personnel records on May 13, 2009 revealed the GHMRP failed to have evidence of physical examination for four direct care staff [Staff #1, #2, #3 and #4] and four consultants. (Pharmacist, Nutritionist, Social worker and Registered Nurse).

I 206

I 222 3510.3 STAFF TRAINING

There shall be continuous, ongoing in-service training programs scheduled for all personnel.

This Statute is not met as evidenced by:
Based on observation, staff interview and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employee to perform his or her duties effectively, efficiently and competently for one of the four Resident's residing in the facility. (Resident #3)

The findings include:

The facility failed to ensure that direct care staff documented program data according to the IPP

I 222

3510.3

The QMRP retrained staff on properly documenting the behavior episodes of client #3, focusing on both actual episodes of the behavior verses attempts to engage in the behavior...5-30-09.
The licensed psychologist will conduct follow up training by...6-15-09.

Health Regulation Administration

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I 222	Continued From page 4 objectives. [See Federal Deficiency report Citation W252]	I 222		
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health (DOH), Health Facilities Division was immediately notified, followed by written notification within 24 hours, of unusual incidents that substantially interfered with a resident's health, for two of the four residents that resided in the facility. (Resident #1 and #3) The findings include: The review of the facility's unusual incident management system and interview with the Qualified Mental Retardation Professional (QMRP) on May 12, 2009 at 9:45 AM, revealed the facility failed to timely notify the to the governmental agency of the following incident(s): 1. Review of an unusual incident report, dated July 10, 2009, reported that Resident #1 was observed with injury of unknown origin to his	I 379	3519.10 1. The injury to client #1's upper left eye was not of unknown origin it was based on a behavior episode where he hit himself. His injury was assessed by nursing, deemed very minor with minimal follow up treatment required. The slight bruise to the area resolved itself in a matter of days and client #1 exhibited to pain or discomfort during the healing period. The QMRP will retrain staff on appropriately completing incident reports and notifying the appropriate parties. The training will occur by...6-7-09. 2. Staff will be retrained on incident reporting, in addition, the MTS staff IMC now insures that all incidents are reported to DOH and other required entities in a timely manner on a consistent basis...6-1-09.	

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I 458 Continued From page 6

Further interview with the QMRP revealed the activity schedule should have been revised after the resident's ISP meetings respectively. According to the QMRP, Resident #1's ISP meeting occurred on 1/7/09 (four months prior) and Resident #2 ISP meeting occurred on 10/7/08 (seven months prior). At the time of the survey, however, there was no evidence that the each resident's activity schedule had been updated and included their current IPP objectives and was available for the direct care staff working in the facility.

I 458

I 473 3522.4 MEDICATIONS

The Residence Director shall report any irregularities in the resident ' s drug regimens to the prescribing physician.

This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that medications were administered in compliance with the physician's orders, for one of the two clients included in the sample. (Client #2)

The findings include:

Observation of the medication pass on May 12, 2009 at approximately 7:13 PM, revealed that the medication nurse was unable to administer Client #2's PM dosage Mysoline 50 mg for his seizures because the medication was not available in the facility.

Further interview revealed that the agency's nursing policy revealed that the LPN and the RN are to monitor the medication supply to ensure that each client's medications are available for administration.

I 473

3522.4

MTS has established a nursing support office staffed with two support LPNs who are charged with ordering and tracking the delivery of required medications, among other tasks, using this office and other nursing supports in place, MTS will insure that all needed medications are obtained from pharmacy in a timely manner...6-1-09.

It should be noted that client #2 missed one dose of the medication, the PCP was informed and there were no ill effects noted.

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1473	<p>Continued From page 7</p> <p>Review of the Medication Administration Records (MAR) revealed on the same day revealed that the nurse signed the back of the MAR that the medication was unavailable. According to the LPN she notified the RN who in turn contacted the pharmacy. The nurse confirmed that the medication would be delivered later in the evening and administered by the RN.</p> <p>On May 13, 2009 at approximately 10:15 AM follow up with the RN revealed that the pharmacy failed to deliver Client #2's medication the pervious evening. Review of the nurses note on the same day at 10:30 AM did not evidence that the RN contacted the physician to report the missed dosage of medication and did not evidence instructions for Client #2's missed dosage of medication.</p> <p>At the time of the survey, there was no evidence that Client #2 received his dosage of medication as prescribed for his seizures.</p>	1473		